CONSUMER COMPLAINT FORM

GREGORY D. STUMBO ATTORNEY GENERAL



RETURN TO: Office of Attorney General Consumer Protection Division 8911 Shelbyville Rd. Louisville, KY 40222 (502) 425-4825-Louisville Office Hotline: 1-888-432-9257

www.ag.ky.gov/cp

TYPE OR PRINT NEATLY. SUBMIT TWO COPIES OF THE COMPLAINT AND TWO COPIES OF ANY DOCUMENTS SUBMITTED. YOUR NAME **ADDRESS** CITY ______STATE ____ZIP CODE ____COUNTY ____ HOME PHONE ______ WORK PHONE ____ COMPANY OR PERSON(S) YOUR COMPLAINT IS AGAINST_____ ADDRESS _____ CITY _______STATE _____ZIP CODE _____PHONE NO. _____ Please fill in this section completely. WAS A CONTRACT SIGNED? YES NO (If Yes, Please Attach a Copy of Your Contract.) DATE(S) OF TRANSACTION ______ PRODUCT OR SERVICE INVOLVED____ TOTAL PRICE ______ AMOUNT PAID______ WAS PRODUCT/SERVICE ADVERTISED? \(\textstyle \text{YES} \) NO HOW WAS SERVICE ADVERTISED? ☐ Newspaper ☐ TV ☐ Radio ☐ Mail ☐ Phone ☐ Internet ☐ Other WITH WHAT OTHER AGENCIES HAVE YOU FILED THIS COMPLAINT? _____________________________ WHAT ACTION WAS TAKEN? HAVE YOU HIRED OR RETAINED A PRIVATE ATTORNEY? \square YES \square NO HAVE YOU STARTED COURT ACTION? \square YES \square NO WHAT ACTION WILL RESOLVE YOUR COMPLAINT?

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	Below, briefly state the facts of your complaint (if necessary, use additional paper). Please attach copies of any papers involved (order blanks, warranties credit card receipts or statements, contracts, advertisements, canceled checks, etc.). The information you provide will be used in our effort to resolve your problem and may be shared with the party against which you have complained. It may also be used to enforce applicable state laws. Under Kentucky's Opel Records Act, this complaint will be available for public view upon request. Certain personal information such as account numbers are not subject to the Oper Records Act.)
ADDRESS		
ADDRESS	If Your Complaint is Regarding a Mobile Home Transaction, Also Complete this Section.	
ADDRESS	NAME OF MOBILE HOME MANUFACTURER	
If Your Complaint is Regarding a Health Club Membership, Also Complete this Section. WAS CONTRACT SIGNED? YES NO DATE OF CONTRACT LENGTH OF CONTRACT: YEARS MONTHS TIME LEFT BEFORE CONTRACT EXPIRES: YEARS MONTHS TOTAL AMOUNT OF YOUR CONTRACT: AMOUNT PAID TO DATE: S WHEN WERE YOUR PAYMENTS TO BE MADE? MONTHLY YEARLY J'HER AMOUNT OF EACH PAYMENT? MENDEN OTHER THAN THIS HEALTH CLUB? YES NO If yes, please provide the following information: NAME: ADDRESS: CITY, STATE, ZIP: The above information is true and accurate to the best of my knowledge. TODAY'S DATE YOUR SIGNATURE OPTIONAL—COMPLETION OF THIS SECTION IS VOLUNTARY		
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